1. INTRODUCTION

On September 12, 1993, a 34 year old Montana father of two died from Hantavirus infection. Within 24 hours of confirming the cause of death with the national Centers for Disease Control and Prevention, a team from the Cascade City/County Health Department, the State's health agency and the CDC were on the job working collaboratively to keep the medical community and the public informed of the health concerns, and staffing a ***Hanta Hotline*** *to answer hundreds of calls from concerned Montanans about their risk of exposure.*

In the summer of 1995, an outbreak of E.coli poisoning was reported in Missoula. Over 70 cases of the disease were reported over a 12-day period. Working together, the Missoula City-County Health Department and the Department of Public Health and Human Services studied potential sources of the outbreak and put into place measures to ensure that the threat of further exposure was contained.

On September 23, 1996, 21 Hamilton High School chemistry students were taken to the local hospital emergency room after complaining of ill health, dizziness, headaches, and nausea. The school was evacuated and the local Disaster and Emergency Services requested assistance from the Ravalli County Public Health Department and the State Departments of Public Health and Human Services and Environmental Quality. After highly sophisticated air quality testing, the state epidemiologist and air quality specialists determined the students' symptoms to likely have occurred from mechanical problems in the building, providing school official with the information necessary to make corrections.

Life expectancy in the United States has increased by about 30 years since the turn of the century. While five years of that increase can be credited to advances in clinical medicine, 25 of those years are the result of this country's public health efforts to improve sanitation and nutrition, control the spread of communicable

diseases and reduce injuries.[1] Today, however, funding for public and preventive health services is being eroded by diminishing state and local resources and competition for funds with the escalating cost of personal medical services. In 1993, less than 1% of all money spent on health care in the United States was invested in public health services.

While increasing access to medical care can reduce the burden of disease and injury to society, a much greater impact on health and the overall cost of health care can be reached by preventing disease and disabling injury. The prevention approach of public health has provided the basis for dramatic improvement in health and life expectancy. Unfortunately, public health funding is jeopardized by competing demands in the health sector.

Between 1981 and 1993, health costs in the U.S. have increased by more than 210%. Funding for population-based public health strategies decreased 25% over the same period. The diminishing funds for public health have compromised efforts to monitor community health, prevent disease and disability, and have made it difficult to continue these important programs.

The reduced priority given public health funding occurred at a time of increasing demands for public health intervention. During this period, the AIDS epidemic surfaced, tuberculosis and measles outbreaks re-emerged and the problems of substance abuse, violence and teenage pregnancy escalated. Without a strong public health system, communicable diseases will increase and injuries and chronic diseases will occur at a much greater rate. Action must be taken by communities and elected officials to assure that the safeguards of public health are maintained.

One in eight Montana women will develop breast cancer in her lifetime. American Indian women in Montana have 3 to 5 times more cervical cancer than any other group in the United States. Community planning coalitions, with support from the Centers for Disease Control and Prevention will begin cancer screening programs that will reach 4,000 older women and American Indian women beginning March, 1997. This program will significantly improve the likelihood of finding breast cancer early enough to increase the life expectancy and quality of life for many Montana women.

[1] For a Healthy Nation: Returns on Investment in Public Health, U.S. Department of Health and Human Services, Public Health Service, 1995.

By conducting activities such as assuring food safety, monitoring health care systems and protecting against illness in the workplace, public health agencies are working together with the private sector to significantly reduce illness, death and disability. Through services to their communities, such as conducting immunization clinics, providing laboratory testing, monitoring diseases and responding to disease outbreaks when needed, public health agencies are preventing and controlling the spread of communicable diseases.

Public education also plays a major role in preventing diseases and disabling injuries by changing both the community's and the individual's behaviors. Community organizations, health care providers and other groups contribute to many health promotion activities and are essential partners in public education efforts. The public health agency, however, is the only entity with the overall responsibility for identifying threats to the health of the community, and conducting programs of public education and services focused on the removal of those threats.

Since its formation, the Montana Diabetes Project Advisory Coalition has distributed over 350,000 written diabetes risk tests. As a result, a majority of Montana's population has a heightened public awareness about diabetes and related risk factors. Through partnerships between the state's Diabetes Prevention Program, Blue Cross and Blue Shield, and the American Diabetes Association, the distribution of these tests was accomplished free of charge.

Nationwide, state funds account for 41% of state public health funding. In Montana, state funds represent less than 15% of state public health spending. More support is needed for important public health activities like disease and injury surveillance, health education, and promotion. These shortages are particularly serious at the local level where a 1994 study indicated that the majority of Montana counties were at 25% to 50% capacity on many basic public health services.[2]

This Public Health Improvement Plan seeks to identify the core Functions of public health in Montana and to propose public health Responsibilities for assuring that Montana's health status is maintained through control of preventable disease and environmental risk. The health of our residents cannot be maximized nor can the rising costs of health care be stemmed unless unnecessary death, disease and disability are prevented.

[2] From a summary of a survey on the *Adequacy of Public Health Core Functions In Montana Counties,* reported in Public Health Improvement Plan: A Proposal to the Montana Health Care Authority, Montana's Committee for Improving Public Health, 1994.

1.1 What is Public Health?

The Public Health Improvement Task Force defines public health as ***an applied science designed to promote individual, community and environmental health by understanding, anticipating, and responding to the health-related needs of Montanans in their communities***. As seen in the following list, public health Responsibilities and activities are extensive and their contributions are vitally important to the health of Montana's citizens.

PUBLIC HEALTH IN MONTANA:

- **Prevents Epidemics** — Including chronic and infectious disease surveillance; rapid response to outbreaks; epidemiological investigations.
- **Protects the Environment, Workplaces, Housing, Food and Water** — Including air and water quality; assessment of environmental health risks; food/restaurant inspection responsibilities; waste disposal/sanitation monitoring and enforcement.
- **Monitors the Health Condition of the Population** — Including the assessment, monitoring and surveillance of local health problems and need for resources for dealing with them; establishment of statewide, standard data base.
- **Promotes Healthy Behavior** — Including health education to promote healthy behaviors and reduce the prevalence of communicable and chronic diseases; comprehensive school-based health education programs; nutritional counseling/dietary services; enhancing the public's understanding of public health's role.
- **Develops Policies to Promote Health** — Including providing statewide standards for public health services; leading the development of sound health policy and planning at the local level; ensuring public health advocacy in the political process; providing scientific guidance for policy decisions and regulatory support for policy implementation and enforcement; collaborating with other public and private agencies to respond to community health needs; regionalization of services.

- **Trains Specialists in Investigating and Preventing Diseases** — Including expanding continuing education opportunities; increasing access to public health training programs through innovation, telecommunications and direct support; ensuring that other health professional training programs include unique public health skills such as epidemiology and biostatistics.

- **Assures that Health Services are High Quality and Necessary** — Including securing a skilled public health work force; assuring that high quality services, including personal health services, needed for the protection of public health in the community are available and accessible to all persons; building partnerships with other health care providers at local and state levels; state laboratory testing services; providing health services when needed.

- **Mobilizes Communities for Action** — Including adult and childhood immunizations; targeted case management services; perinatal services, Children's Special Health Services; well child clinics, including dental; STD/HIV screening; school screening programs; family planning services; nutrition services; cancer prevention; cardiovascular disease prevention.

- **Responds to Disasters** — Including response to toxic spills, safe water sources, control of chronic/communicable disease.

In 1988, the Institute of Medicine conducted an extensive study of public health in the United States,[3] and concluded that the public health system in this country has been extremely successful in promoting health and preventing disease. The report cautioned, however, that the basic infrastructure of our public health system has been deteriorating at an alarming rate.

Ironically, the success of public health programs in controlling diseases and reducing injuries has contributed to a decline in funding for public health services. Since many activities that control diseases and environmental risks occur with little public attention, communities often are unaware of the resources required to conduct these successful public health system measures, especially when many diseases now present little risk to the community. Tuberculosis (TB) is a good example.

[3] *The Future of Public Health*, Institute of Medicine, National Academy Press, 1988.

In 1994, a 21-month-old Montana child died from tuberculosis, a disease thought to be all but eliminated in the U.S. An aggressive public health investigation at the county and state levels determined the father to be the source of infection for the child. Of the 48 contacts to the father, 2 more cases of TB were confirmed, including his wife and a co-worker. Further transmission was prevented through public health follow-up of each case, which continued for 15 months until all had completed an adequate course of TB therapy.

In the early 1900's when statistics on tuberculosis were first collected, hundreds of TB cases were reported each year in Montana. With the discovery of effective antibiotic therapy in the 1950's and 1960's, the number of TB cases in Montana and nationally dropped steadily each year. Consequently, as TB became less of a problem, funding for TB programs and treatment decreased at the local, state, and federal levels. While Montana has not experienced huge increases in state rates as some large metropolitan areas have, the annual decline in the number of TB cases has ended.

Not only has TB not been eliminated in Montana and the nation, the emergence of drug-resistance makes it a bigger threat than ever before. While almost always treatable, the public health sector now knows the successful elimination of TB involves much more than just the availability of a clinical drug regimen. The emergence of drug-resistant TB has primarily resulted because patients do not take their medications as prescribed. Following the medication directions for each individual infected with TB is the highest priority of a public health program. In 1995, over half the TB cases in Montana were managed through direct observation.

Another important factor in the decline of public health services has been an increasing reliance of public health agencies on Federal “categorical” funding. Categorical funding that comes from Federal sources focuses primarily on specific diseases and health conditions. These funds provide support for direct services to individuals at the local level for health and environmental priorities that are determined at the national level, such as immunizations, maternal and child health services, AIDS/STD testing, tuberculosis, asbestos removal, and maintaining water quality.

The increased reliance on Federal sources of funding comes at a time when State funding is being reduced. Consequently, many local problems that do not fall into Federal “categories” often cannot be addressed. Further, since categorical funds offer little support for building the overall capacity of local public health agencies to serve the needs of their communities, local public health agencies are finding it more and more difficult to provide basic public health functions that have historically been

successful in controlling disease outbreaks, reducing environmental risks, and improving the health of the community.

1.2 Public Health in Montana Today

Today, Montana's local public health system is operated by county, city/county, or multi-county district agencies that are administratively independent of State government. There are 51 local public health jurisdictions, each reporting to a local "Board of Health." In carrying out their functions, Montana's local public health agencies work with the Departments of Public Health and Human Services and Environmental Quality.

Availability of resources, both economic and professional, as well as services provided by local public health agencies varies widely across the state. Although some local agencies have responded to reduced State funding and reduced flexibility in use of categorical Federal funding by increasing local public health funding, most have been forced to cut back on services. In most cases, reduction in local public health services is based on lack of funds, and therefore does not correspond to local needs and priorities.

Public health functions provided by the State also have suffered from years of funding based on "popular" concepts of public health needs that are driven by Federal policies. There has not been a comprehensive statewide plan for the long range control of health risks and promotion of conditions and behaviors that improve the health of Montanans. Like local public health programs, public health at the State level has been organized around the categories of Federal funding. This has resulted in a mixture of service and support activities, some of which are integrated well with local public health services and many which are not. Too often State functions that are designed to directly support local public health programs are unable to effectively serve many areas of the state since local agencies lack the personnel and resources necessary to participate in the activity or service.

The greatest strength of the Montana Public Health System is its public health professionals. These dedicated workers provide services in every corner of the state. Because Montana is so rural and sparsely populated, most of these public health professionals must assume a wide range of responsibilities and duties, requiring them to develop broad skills and knowledge. Thus, while there may be few workers in many parts of the state, the broad skills of these professionals enable local public health agencies to respond quickly and effectively to a wide range of community health needs.

1.3 The Montana Public Health Improvement Act

Since the late 1980's, public health professionals and public officials in Montana have been increasingly concerned that local and state public health services are being reduced or eliminated based on availability of funding rather than need. Because of conditions attached to most federal categorical funds, only state or local resources can easily be shifted from one public health priority to another. Often, when local public health agencies move limited resources to address a public health risk that is more severe or pressing it means reducing or eliminating another public health service that also is needed. Therefore, important public health needs of communities cannot be met in many cases if specific Federal or State funding is not available.

These concerns prompted a group of state and local public health officials to convene a conference of local and state public health providers in February, 1994, to address the role that public health should play in state and national health care reform. The conference focused on describing public health in Montana, and resulted in an outline of core public health functions and services as they apply uniquely to Montana.[4]

Following a recommendation from that conference, a group of concerned local and state professionals formed the *Committee for the Improvement of Public Health in Montana*. One of the charges to that committee was to conduct a survey of local public health agencies to determine their ability to perform the public health functions that were outlined during the conference. The survey results indicated that most local agencies had the ability to perform fewer than half of the functions fully, and those local agencies with the least resources had little or no ability to perform any of the functions.

Subsequently, Representative Bill Tash (Dillon) and Senator Mignon Waterman (Helena) jointly introduced the **"Public Health Improvement Act"** (see Appendix A) which was passed by the 1995 Montana Legislature. The purpose of the Act was ***"... to assist local governments and community organizations to determine the most serious threats to public health, to determine a method to address those threats, and to provide local and state decision makers with a framework for prioritizing public response to those threats."***

---

[4] The description of public health in Montana provided in Section 1.1 of this report was taken from the proceedings of the conference on *The Role of Public Health in Health Care Reform*, February 25, 1994.

To carry out the activities of the Act, creation of a *Montana Public Health Improvement Task Force* was authorized. The Task Force, with the support of the Montana Department of Public Health and Human Services, was charged with preparing a "public health improvement plan" that addresses the following subjects:

- The ability or capacity of local boards to provide Core Functions and the standards by which that capacity must be measured, including:
  - a determination of public health strengths and weaknesses in communities and the state;
  - a determination of which municipalities do not meet capacity standards established by the task force;
  - an analysis of the costs and benefits of adoption of capacity standards; and
  - a plan for municipalities in order to achieve the capacity standards established by the task force.
- Strategies for improving state and local public health programs, including:
  - a determination of the needs of local boards, municipalities, and state agencies in order to achieve the capacity standards established by the task force in the most critical Core Functions;
  - an examination of a strategy, such as establishment of geographic regions, for cost-effective administration and delivery of public health services;
  - identification of methods to network local public health services to each other and to state public health services; and
  - a review of laws, rules, ordinances, and policies pertaining to public health.
- Consideration of population-based public health activities, including:
  - assessment of health data;
  - surveillance of chronic and infectious diseases;

- rapid response to outbreaks of communicable diseases;
- efforts to prevent and control communicable diseases, such as tuberculosis and AIDS;
- health education to promote healthy behaviors and to reduce the prevalence of chronic diseases, such as those linked to tobacco, poor nutrition, and lack of proper physical activity, and cardiovascular disease, cancer, and diabetes;
- access to primary care in coordination with community-based health organizations;
- programs to ensure that children are born as healthy as possible and that they can receive immunization and adequate nutrition;
- efforts to prevent injury;
- programs to ensure the safety of drinking water and food supplies;
- control of poisons;
- services for treatment of trauma; and
- other activities that have the potential to improve the health of the population or special populations and to reduce the need for or costs of health services.

- A plan for the funding of other parts of the plan, including:
  - a recommended level for funding public health services, to be expressed in a percentage of total health services expenditures in the state in a set per capita amount;
  - methods to ensure that proposed funding does not supplant existing funding; and
  - identification of federal and private funding opportunities.

- Identification of methods of integrating health status data into the health planning process and into local and regional planning;

- Recommendations for coordinating public health improvements with health care reform efforts and for continuance of the task force beyond 1996.

- A plan for implementing the recommendations contained in the plan in the years 1997 through 1999.

1.4 Overview of the Task Force Planning Process

In July, 1995, Governor Marc Racicot appointed the members of the Public Health Improvement Task Force based on the provisions of the Act. The Task Force held its first meeting in Missoula on October 17, 1995, and met frequently thereafter.

The Task Force patterned its planning process after the requirements of the Act and a similar effort by the State of Washington that completed the Washington *Public Health Improvement Plan*.[5] As the Task Force began deliberations, it started with the premise that assessing threats to public health is a continuous process and therefore is the first and primary responsibility of public health programs. From this premise evolved a planning process that involved ten major steps. The following sections of this report provide highlights of the Task Force planning process.

N **Step 1:** An agreement was reached on the framework for Montana's public health improvement planning process that included an overview of the Washington *Public Health Improvement Plan* and the planning process was presented to the Task Force by Dr. Mimi Fields, of the Washington Department of Health.

N **Step 2:** The Task Force reached consensus on Montana's definition of public health and its six Core Functions.

N **Step 3:** The Task Force drafted a set of proposed State and local public health "Responsibilities" that are necessary to perform each of the six Core Functions.

[5] The methods used for development of the Washington plan are contained in*: Public Health Improvement Plan*, Washington State Health Department, November 1994.

- **Step 4:** The Task Force presented the proposed Core Functions and Responsibilities to public health professionals in five regional work sessions to obtain feedback and comments on the appropriateness and feasibility of implementing the functions and responsibilities.

- **Step 5:** A resource survey and inventory of all 51 local public health jurisdictions was completed for the Task Force by a team of graduate students in the University of Montana's Public Administration program to obtain a general understanding of resources available to implement the proposed Core Functions and Responsibilities.

- **Step 6:** The Health Policy and Services Division of the Department of Public Health and Human Services completed a health status report for the Task Force to serve as an indicator of the need for ongoing public health services in the state.

- **Step 7:** A review of public health laws and policies was completed in an attempt to understand who or what agency is responsible for public health in Montana.

- **Step 8:** The steps needed to conduct ongoing public health improvement activities in Montana were outlined, including recommended actions for the Montana Legislature, the Department of Public Health and Human Services, and the Public Health Improvement Task Force.

- **Step 9:** The Task Force completed a framework that will be used to determine the funding necessary to implement a statewide public health improvement plan based on the Core Functions and Responsibilities identified through the planning process. This framework included a plan for funding the ongoing activities of the Task Force to develop, implement and evaluate the public health improvement plan, and identified the need for resources that will assist local public health agencies to meet the Core Functions and Responsibilities proposed by the Task Force.

- **Step 10:** The Task Force developed this Plan with recommendations to assist in providing information to county commissioners,

legislators, state and local public health officials, boards of health, and the public. Additionally, this Plan provides a framework to continue public health improvement activities.

2. HEALTH STATUS OF MONTANANS

In general, Montanans are a healthy lot who share a strong concern and appreciation for the healthy environment in which they live. Maintaining the high quality of our air, water, and lands has led Montanans to support strong environmental protections and standards, and to be vigilant against threats to the environment that may affect our health. In Montana, our public health system works to ensure that we have water that is safe to drink, sewage and sanitation systems to protect our communities from diseases, clean restaurants in which to dine, protective standards to keep our air breathable, response systems to prevent disease outbreaks and epidemics, and ways to identify our greatest health problems and find solutions.

Clearly, Montana's public health system is offering Montanans the possibility of longer, healthier, and more productive lives. We have been successful in controlling the serious risks of communicable diseases through immunizations and the effective control of disease outbreaks associated with animals and food service. Without reducing these effective efforts, Montana's public health system must now focus on accidents and illnesses that shorten life or make it less productive.

Today in Montana, the public health system is working to improve and protect the health of all Montanans through efforts like:

- conducting campaigns to increase seatbelt use;
- setting standards to ensure restaurant food is safe to eat;
- providing needed health and nutritional care to women with high-risk pregnancies through programs like the Montana Initiative for the Abatement of Mortality in Infants (MIAMI);
- enacting laws requiring children to be vaccinated, and educating parents on the importance of having their children immunized;
- finding and treating people who have been exposed to communicable diseases;
- enforcing laws to prevent dumping of toxic wastes; and
- developing educational programs to reduce teen tobacco use.

Montana's public health system has been invaluable in reducing the risk and consequences of communicable diseases in the state. For example, occurrences of once deadly diseases such as smallpox, tetanus and rabies are almost nonexistent.

Recent recurrences elsewhere in the U.S. of health problems thought to have been eliminated, however, indicate that the public health system must not cease or reduce these efforts.

In Montana, like anywhere else, we should not let successes in certain areas of public health lead us to believe that health threats do not still exist. Most preventable health problems in Montana — including as many as half the deaths — are caused or aggravated by societal behaviors like tobacco use, improper diet, lack of exercise, alcohol misuse, drug abuse, misuse of firearms, unsafe sexual behavior, and motor vehicle accidents. The combined efforts of public health and personal medical care can influence the behavior of the individual at risk for these fundamental causes of illness, injury, disability, and premature death. The public health system seeks to protect our communities from health threats, to mobilize efforts to promote health and healthy lifestyles, and to anticipate and prevent injury and disease.

2.1 Current and Future Health Concerns of Montanans

Today, the major causes of death for Montanans under 65 years of age are accidents, suicides, and chronic diseases. Most of these are preventable through effective public health programs of education, screening, and care. The following health status examples illustrate current and future concerns for public health in Montana:

- Chronic diseases affecting those under 65 are cancer, heart disease, diabetes, and respiratory illnesses -- chronic obstructive pulmonary diseases (asthma, bronchitis, and similar illnesses), pneumonia, and influenza.

- Cancer and heart disease are leading causes of death in Montana as in the U.S., but Montanans under 65 are more likely to die of cancer than of heart disease. Men are likely to succumb to heart disease at an earlier age than women. Whites are more likely to get cancer than non-whites, but non-whites having cancer are more likely to die of it within five years of diagnosis.

- Montana's suicide rate is among the highest in the nation. When adjusted for age, it is nearly 50% higher than the national rate. Most

suicides in the U.S. and in Montana are males. In the state, the highest suicide rate is for non-white males between 15 and 34 years of age.

- Montana experiences a much higher incidence of death from motor vehicle accidents than national rates. For all age groups, accidental death rates from motor vehicle accident are higher for men, especially young men, than for women. For all age groups, motor vehicle accident rates are higher for non-whites than for whites, 2.5 to 3 times higher for non-whites age 15 through 34.

- Tobacco-related deaths account for nearly one-fifth of all deaths in Montana and there are more tobacco-related deaths than combined deaths from traffic accidents, alcohol and drugs, homicides, suicides, and AIDS. Smokeless tobacco use is reported by one of every three high school males in Montana, more than twice the national rate.

- Non-white women are more likely to become pregnant at younger ages and much less likely to receive early prenatal care than white women.

- Non-white mothers are more likely to have high birthweight infants than white mothers. However, non-white infants are more likely to die during the first year of life, regardless of birthweight.

- Infant death rates have decreased for newborns of all races (the first 27 days of life). However, the death rate in Montana for infants between 28 days and one year of age is almost double the Healthy People 2000 goal for all races. The problem is even worse in our American Indian population. Sudden Infant Death Syndrome (SIDS) death rates are higher in Montana than they are nationally.

- Mothers who are unmarried during their pregnancies are most likely to be 18 to 24 years of age.

- Diabetes was the seventh leading cause of death in Montana in 1994, accounting for more deaths than suicides that year. It affects Montana men and women about equally, but non-whites are more likely to die of diabetes than whites, and they are more likely to die at an earlier age.

- Human Immunodeficiency Virus (HIV) has not become the problem in Montana that it is elsewhere in the country, but it is one of the six leading causes of death for the 25 to 34 year old population. It accounted for 6

deaths in that group in 1993 and 1994, and 26 deaths overall, including two women in 1994.

2.2 Montana's Public Health Response

Traditional approaches to health and health care problems in Montana are being redefined at the community level. Many communities are being empowered to take ownership and direction of local health problems. Citizens in communities like Polson, Livingston, Sidney, Billings, and Missoula are taking the initiative to create “healthy communities” by working together on projects to reduce teen pregnancy, curb violence in schools and the community, improve child care options, and discourage use of drugs, alcohol and tobacco. Public health agencies are working collaboratively in their communities to define priorities and work to improve the community's overall health status.

A positive public health system change in Montana has resulted from more community partners being involved in public health. New public/private partnerships are being created that increase opportunities for Montana families and individuals to grow and develop in safe and healthy communities.

The growing presence of managed care plans and HMO's in the state is creating a need for primary health care to be more involved in public health functions than ever before. This involvement, however, can never replace the important population-based functions of the public health agency. For example, while the provider may identify a child with lead poisoning, it is the public health agency that is responsible for assuring that the lead paint is removed from the child's home or school, for monitoring children to ensure further poisoning does not occur, and for enforcing building codes.

3. PUBLIC HEALTH IMPROVEMENT IN MONTANA

An important approach to improving Montana's public health is to provide basic public health services across the state. The Task Force determined that the following steps were necessary to accomplish this goal:

- develop a general definition of public health;
- develop a set of Core Functions and public health Responsibilities that could be used to assess the needs and capacity of local jurisdictions to provide basic protections and services;
- determine the specific public health Responsibilities that are necessary to carry out the Core Functions;
- review the public health laws, rules, and ordinances; and,
- gain acceptance of the Core Functions and public health Responsibilities from elected officials, health care providers and the public.

3.1 Proposed Core Functions and Public Health Responsibilities for Montana

As indicated in Section 1, the Task Force has defined public health as an applied science designed to promote individual, community and environmental health by understanding, anticipating, and responding to the health-related needs of Montanans in their communities. The policies and services of public health represents an investment in six Core Functions for health promotion and disease prevention and intervention efforts.

The Task Force worked with public health agencies to develop consensus on the following set of Core Functions and Responsibilities.

Core Functions:

- ***Assessment of Health Status, Trends, Risks and Resources*** - Assessment is the regular collection, analysis, and dissemination of information about health trends, status, risks, and resources within the community and state. It identifies: trends in illness, injury and death, and the factors which may cause these events; available resources and their application and community perceptions about health issues.

- ***Health Promotion*** - Health promotion is a process of assisting individuals, acting separately and collectively, to make informed decisions on matters affecting individual, family, and community health. It includes health education and the fostering of healthy lifestyles and environments through activities encouraging action to acquire skills, use accurate information and achieve change when needed.

- ***Protection from Health Risks*** - Protection from health and environmental risks means controlling and reducing the exposure to a population's environmental and personal hazards, conditions, communicable and chronic diseases, and factors associated with health problems.

- ***Assurance of Health Service Availability and Quality*** - Assurance of health service availability and quality involves commitment to making available and accessible high quality services, including personal health services, in communities. Effective assurance activities require building partnerships and negotiating with other health care providers at state and local levels, maintaining efficient state laboratory services, providing needed health and medical services when otherwise unavailable, and developing planning and response functions in the event of an outbreak or emergency. Assurance activities also focus on primary and prevention services, public health nursing, and home-based services.

- ***Policy Development*** - Policy development refers to planning and implementation functions, supported with valid information, to guide individual and community health efforts. It is dependent on cooperative federal, state, and community involvement to implement operational goals and objectives aimed at improving the health of communities and individuals.

Ó ***Leadership, Technical Expertise and Administration*** - Leadership, technical expertise and administration are necessary for the effective assignment and completion of essential public health functions. These roles include: employing skilled public health professionals; planning, mobilizing, and using resources effectively; responding to environmental changes; communicating public health values; and enlisting community commitment to public health.

Public Health Responsibilities:

The public health Responsibilities were developed under the guidance of the general definition of public health and the six Core Functions. The Responsibilities are explicit statements of what public health agencies, along with other state and local partners, must do in order to adequately protect and promote health, and prevent disease and injury (the public health Responsibilities are presented in Appendix B with proposed local and state program levels provided next to each Responsibility). Following are two examples of public health Responsibilities:

U *Make follow-up inspections and assist with enforcement actions as needed. Adopt at least minimum onsite waste water treatment system (septic system) regulations.*

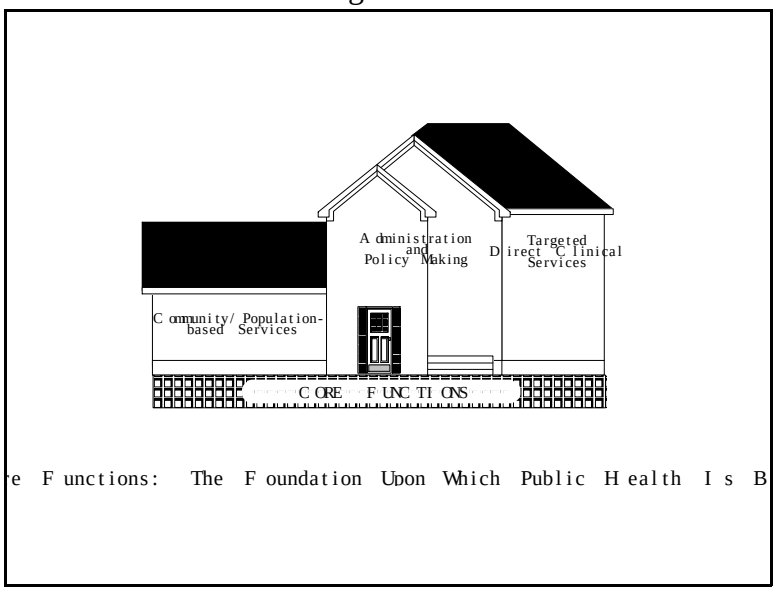
U *Coordinate with other local and state agencies to provide epidemiologic and inspection services to determine the public health impact of communicable disease outbreaks, environmental emergencies, or hazardous material spills.*

Because early recognition and intervention has such great potential to reduce death, disability and expense, the Task Force is emphasizing the need for flexible funding systems which allow for the provision of public health Responsibilities. Local public health agencies need to maintain constant surveillance of their community's health status, environmental risks and behavioral risks. This ongoing assessment will permit public health agencies to work with their communities to accomplish early intervention for those conditions identified as local priorities.

The extent to which public health agencies are able to fulfill the Core Functions is determined by their ability to carry out specific public health Responsibilities. Because local agencies significantly differ in how they function, the Task Force provided the analogy of a house to illustrate how Core Functions related to their individual programs (Figure 3.1). Basically, Core Functions represent the foundation of public health at the local level. The architecture for each house (i.e., each county) is

different, with different numbers and types of rooms in each. The foundation for each house, however, is made up of similar ingredients (Core Functions). Should there be a weakness in the foundation in any house, the house itself becomes weakened. Therefore, the Task Force has devoted a great effort to strengthening the foundations of public health through the development of consistent and universal Core Functions with associated Responsibilities.

Figure 3.1

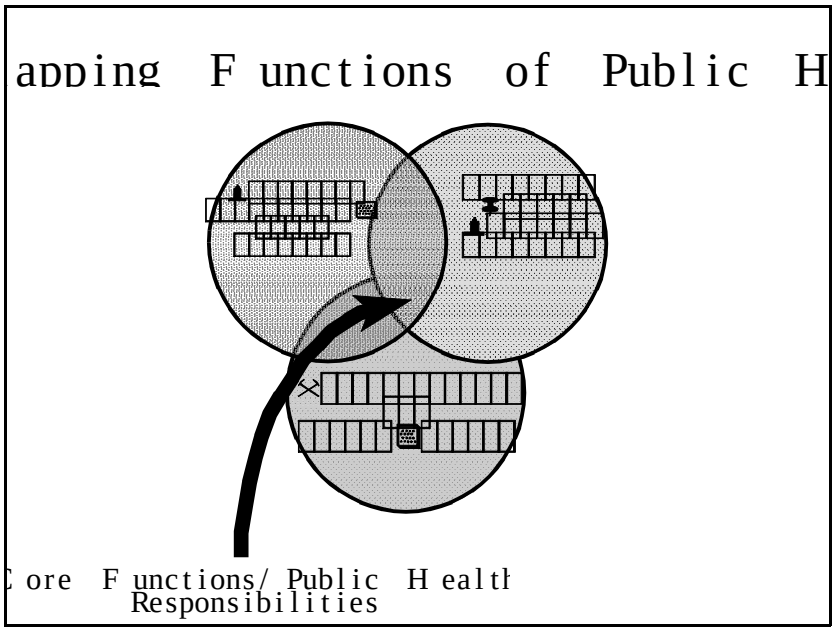


e Functions: The Foundation Upon Which Public Health Is B

It is important to recognize that public health agencies are not directly responsible for carrying out every one of these Responsibilities. In many instances public health agencies contract with other entities, or they have an even less direct, but still crucial, role in coordinating with other entities to assure that necessary work is done. Using the house analogy, these other participants will make up specific walls or rooms of the house. Another way to look at the overlapping relationships among public health functions in the community is illustrated in Figure 3.2 on the next page. As that diagram suggests, the Core Functions and Responsibilities are at the heart of public health and overlap with all services and operations of the system.

3.2 Costs and Benefits of Adopting Public Health Responsibilities

Figure 3.2



The Public Health Improvement Act directed the Task Force to determine costs and benefits of adopting the proposed public health Responsibilities. Just as each local public health agency is different, it is expected that there will be significant differences in the costs of providing Core Functions and associated Responsibilities. Attempting to attach cost figures to Responsibilities requires a great deal of continued work by the Task Force.

In a general sense, it is easier to discuss certain beneficial aspects of adopting public health Responsibilities. Public health programs can significantly reduce the occurrence of conditions that lead to deaths and disabilities. Analysis is available to show cost savings for specific public health interventions such as immunization programs, food safety services, water fluoridation, smoking cessation programs, family planning, and a variety of other services.

The benefits of the core function/public health Responsibilities approach are:

- to provide early intervention because prevention costs the least and has greatest impact;

- to enable public health agencies to sensibly redirect the provision of their services so that those which are no longer needed are ended or those which can be more efficiently and effectively provided by other sectors of the health services system are done so through negotiation; and

2 to assure equitable healthy living conditions in all areas of the state.

As discussed in the recommendations in Section 5, there is much work to be done to determine costs by promoting uniform public health budget reports from counties. As a result, costs of adopting the proposed public health Responsibilities are not readily available for purposes of the Public Health Improvement Plan. However, we do know that dollars spent in public health and preventive services result in considerable savings, for example:

- for every $1 spent on immunizations for measles, mumps, and rubella, $14.00 could be saved on long term costs;
- for every $1 spent on the prevention, cure, and follow-up of sexually transmitted diseases, $2.77 could be saved in health care costs each year;
- for every $1 spent on prenatal care and WIC, approximately $3.39 could be saved in medical care to children; and
- for every $1 spent on dental sealants, $4.27 per year could be saved in other dental treatment costs.

Additionally, there is recent information from other states which looks at costs of conducting Core Functions. In 1993, the U.S. Public Health Service conducted an eight state study of state and local health expenditures in Connecticut, Illinois, Iowa, Missouri, New York, Oregon, Rhode Island, and Texas.[6] In the eight states, an average of $44 per person was dedicated to providing local public health services. This compares to all other health care expenditures (nationally) of approximately $3,500 per person.

The definition of “Core Public Health Functions” used in the study covers all of the minimum and many of the enhanced services recommended by the Task Force. On average, 27% of the total public health budgets in the eight states studied were spent in support of Core Functions, while the vast majority of funds (46%) were spent in personal health services. Further study of Montana's ability to demonstrate where core services are not now adequately funded is necessary to determine the actual costs of statewide provision of public health Responsibilities.

6 Measuring State Expenditures for Core Public Health Functions, Research and Measurement in Public Health Practice ,American Journal of Preventive Medicine, Supplement to Volume 11, Number 6, page 58-73, December 1995.

4. REVIEW OF PUBLIC HEALTH LAWS

The Public Health Improvement Act directed the Task Force to conduct a review of laws, rules, ordinances and policies regarding public health. The following sections describe the content of the law, relate it to public health responsibilities, and provide conclusions and recommendations for making the law more effective. The purpose of the review was to gain a greater understanding of the various roles and Responsibilities by public health agencies, public health officers, and boards of public health. Public health is referred to in numerous statutory provisions in Montana state law (Montana Codes Annotated) and regulations (Administrative Rules of Montana). The following considerations were used to focus this review to the Montana Codes Annotated, rather than also include regulations, ordinances, and policies:

- local ordinances and state regulations come into being through actions typically authorized by state law;
- local and county public health ordinances have evolved with great variation from jurisdiction to jurisdiction;
- public health is a statutorily recognized factor in considering many actions by government, or by entities which must secure government approval before engaging in proposed activities; and,
- public health laws related to state and local public health agencies have the most relevance to the intended purposes of the required legal review of the Public Health Improvement Act.

While there are numerous sections of the Montana Codes Annotated that specifically mention public health considerations (Appendix C), there is no statutory definition of “public health.” Thus the term refers to a variety of different functions and is not limited to the jurisdiction of public health agencies. For example, the following statutory examples use the term public health differently and each is relevant to a different jurisdiction:

- **ö** In the event of an emergency caused by fire, flood, explosion, storm, earthquake, epidemic, riot or insurrection, a county commission (7-6-2341

MCA) or a town council (7-6-4251 MCA) may make expenditures or incur liabilities for the immediate preservation of public health.

- ö No state, local, or inter-jurisdictional agency or public official has the authority to interfere with the course or conduct of a labor dispute except under certain circumstances, including the need to forestall or mitigate imminent or existing danger to public health or safety (10-3-102 MCA).

- ö Volunteer firefighters are authorized to respond to calls for assistance to protect individual or public health and safety (19-17-105 MCA).

- ö It is the state's purpose to promote more research and education on sustainable agricultural practices as related to food and fiber production and distribution where those practices enhance resource efficiency, conservation, and public health (20-25-234 MCA).

These examples indicate flexible, but not unrelated, uses of the terminology "public health". The Task Force has specifically defined public health for purposes of better understanding the roles of local and state public health agencies and their responsibilities to the public. However, it is not the intent of the Task Force to assume its definition should supersede or replace any implied understanding of public health in existing statute, such as the previous examples may offer. The Task Force supports the need for relevant jurisdictions to respond to situations where public health and safety are threatened, and therefore protection of the public health may necessarily take on various meanings for different jurisdictions.

Currently in Montana law are provisions which outline the powers and duties of the Department of Public Health and Human Services (50-1-201 MCA), powers and duties of local boards of health (50-2-116 MCA), and powers and duties of local health officers (50-2-118 MCA). Those statutory responsibilities are illustrated in the table on the following pages (25 through 27).

In comparing the general powers and duties of the three entities, there are no clearly specified relationships between the state and local entities outside of the Department's consultation to school and local community health nurses and boards of health; and, the local health officer's (or his/her designee's) requirement to report sanitary conditions of the county, city, city-county, or district, to the Department. The statutes are silent on the powers and duties of a state health officer, and were modified in 1995 to eliminate the State Board of Health and Environmental Sciences. Significant to this discussion is the fact that the laws do not clearly distinguish a role for state and local public health agencies in relation to other agencies and their deliberations on activities related to public health.

50-1-202.General powers and duties (of the Dept of Public Health & Human Services).	50-2-116. Powers and duties of local boards.	50-2-118. Powers
The department shall: (1) study conditions affecting the citizens of the state by making use of birth, death, and sickness records; (2) make investigations, disseminate information, and make recommendations for control of diseases and improvement of public health to persons, groups, or the public; (3) at the request of the governor, administer any federal health program for which responsibilities are delegated to states; (4) inspect and work in conjunction with custodial institutions and Montana university system units periodically as necessary and at other times on request of the governor; (5) after each inspection made under subsection (4), submit a written report on sanitary conditions to the governor and to the director of the department of corrections or the commissioner of higher education and include recommendations for improvement in conditions if necessary; (6) advise state agencies on location, drainage, water supply, disposal of excreta, heating, plumbing, sewer systems, and ventilation of public buildings; (7) develop and administer activities for the protection and improvement of dental health and supervise dentists employed by the state, local boards of health, or schools; (8) develop, adopt, and administer rules setting standards for participation in and (CONTINUED ON NEXT PAGE)	(1) Local boards shall: (a) appoint a local health officer who is a physician or a person with a master's degree in public health or the equivalent and with appropriate experience, as determined by the department, and shall fix the health officer's salary; (b) elect a presiding officer and other necessary officers; (c) employ necessary qualified staff; (d) adopt bylaws to govern meetings; (e) hold regular meetings quarterly and hold special meetings as necessary; (f) supervise destruction and removal of all sources of filth that cause disease; (g) guard against the introduction of communicable disease; (h) supervise inspections of public establishments for sanitary conditions; (I) subject to the provisions of 50-2-130, adopt necessary regulations that are not less stringent than state standards for the control and disposal of sewage from private and public buildings that is not regulated by Title 75, chapter 6, or Title 76, chapter 4. The regulations must describe standards for granting variances from the minimum requirements that are identical to standards promulgated by the board of environmental review and must provide for appeal of variance decisions to the department as required by 75-5-305. (CONTINUED ON NEXT PAGE)	(1) Local health offi representatives sha (a) make ir conditions; (b) as dire issue written orders removal of filth whic (c) with wri department, order b people congregate (d) on form department, report the department eac (e) before April, July, and Oct local board of sanit city, city-county, or detailed account of containing informati department; (f) before t is given to the local report required by s section to the depa (g) as pres the department, est quarantines; (h) as pres the department, sup places at the expen a period of quaranti (CONTINUED ON

50-1-202.General powers and duties (of the Dept of Public Health & Human Services).	50-2-116. Powers and duties of local boards.	50-2-118. Powers
operation of programs to protect the health of mothers and children, which rules may include programs for nutrition, family planning services, improved pregnancy outcome, and those authorized by Title X of the federal Public Health Service Act and Title V of the federal Social Security Act; (9) conduct health education programs; (10) provide consultation to school and local community health nurses in the performance of their duties; (11) consult with the superintendent of public instruction on health measures for schools; (12) develop, adopt, and administer rules setting standards for a program to provide services to handicapped children, including standards for: (a) diagnosis; (b) medical, surgical, and corrective treatment; (c) aftercare and related services; and (d) eligibility; (13) provide consultation to local boards of health; (14) bring actions in court for the enforcement of the health laws and defend actions brought against the board or department; (15) accept and expend federal funds available for public health services; (CONTINUED ON NEXT PAGE)	(2) Local boards may: (a) quarantine persons who have communicable diseases; (b) require isolation of persons or things that are infected with communicable diseases; (c) furnish treatment for persons who have communicable diseases; (d) prohibit the use of places that are infected with communicable diseases; (e) require and provide means for disinfecting places that are infected with communicable diseases; (f) accept and spend funds received from a federal agency, the state, a school district, or other persons; (g) contract with another local board for all or a part of local health services; (h) reimburse local health officers for necessary expenses incurred in official duties; (I) abate nuisances affecting public health and safety or bring action necessary to restrain the violation of public health laws or rules; (j) adopt necessary fees to administer regulations for the control and disposal of sewage from private and public buildings. The fees must be deposited with the county treasurer. (k) adopt rules that do not conflict with rules adopted by the department: (i) for the control of communicable diseases; (CONTINUED ON NEXT PAGE)	(i) notify th appointment and ch the local board; (j) file a co appropriate court if adopted by the loca department under t (k) validate the department in a 50 through 53 of thi (2) With ap local health officers assemble in a place endangers public h (3) A local physician may be p communicable dise health officer who is to act as a physicia (4) A local physician shall not anyone.

50-1-202.General powers and duties (of the Dept of Public Health & Human Services).	50-2-116. Powers and duties of local boards.	50-2-118. Powers
(16) have the power to use personnel of local departments of health to assist in the administration of laws relating to public health; (17) adopt rules imposing fees for the tests and services performed by the laboratory of the department of environmental quality. Fees, established on an annual basis, should reflect the actual costs of the tests or services provided. The department may not establish fees exceeding the costs incurred in performing tests and services. All fees must be deposited in the state special revenue fund for the use of the department in performing tests and services. (18) adopt and enforce rules regarding the definition of communicable diseases and the reporting and control of communicable diseases; (19) adopt and enforce rules regarding the transportation of dead human bodies; and (20) adopt and enforce minimum sanitation requirements for tattooing as provided in 50-2-116, including regulation of premises, equipment, and methods of operation, solely oriented to the protection of public health and the prevention of communicable disease.	(ii) for the removal of filth that might cause disease or adversely affect public health; (iii) subject to the provisions of 50-2-130, on sanitation in public buildings that affects public health; (iv) for heating, ventilation, water supply, and waste disposal in public accommodations that might endanger human lives; (v) subject to the provisions of 50-2-130, for the maintenance of sewage treatment systems that do not discharge an effluent directly into state waters and that are not required to have an operating permit as required by rules adopted under 75-5-401; and (vi) for the regulation, as necessary, of the practice of tattooing, which may include registering tattoo artists, inspecting tattoo establishments, adopting fees, and also adopting sanitation standards that are not less stringent than standards adopted by the department pursuant to 50-1-202. For the purposes of this subsection, "tattoo" means making permanent marks on the skin by puncturing the skin and inserting indelible colors.	

As noted earlier, responsibilities to public health are peppered throughout Montana laws. Important to this discussion are other statutory provisions associated with specific Department programs (e.g. Vital Statistics; Tuberculosis Control; Pregnant Women and Newborn Infants; Rabies Control; Sexually Transmitted Diseases; Consumer Product Safety Act; Food, Drug and Cosmetic Act; Food and Nutrition; Smoking in Public Places), as well as numerous provisions within the laws governing the actions of the Department of Environmental Quality. In some of the specific sections for programs, responsibilities to interact with other agencies are in place. However, the existence of program-specific laws with defined responsibilities and courses of action do not always coincide with the more ambiguous general powers and duties of the public health jurisdictions noted in the Table spanning the three previous pages.

Statutory language found in Title 7 of the Montana Codes Annotated provides numerous powers and duties of local government. These laws have specific provisions dating to Montana's territorial government in the 1880's. Examples of some of the local government responsibilities include the director of the local department of public welfare having complete enforcement authority of all laws, ordinances, and regulations relative to the preservation and promotion of public health; preventing and restricting disease; maintaining complete and accurate systems for vital statistics; enforcing quarantines; and, sanitary inspections (7-3-4463 MCA).

In the following chapter, mayors are granted powers to enforce health and quarantine ordinances and regulations over all places within 5 miles of the boundaries of cities and towns (7-4-4306 MCA). These types of statutes could potentially present problems for any effort to clearly establish roles and responsibilities for various public health jurisdictions.

4.1 Public Health Responsibilities and Current Law

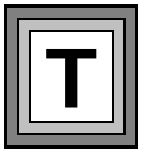
Noted in the general powers and duties of the State Department of Public Health and Human Services, local boards of health, and local health officers are several responsibilities which correspond to the Core Functions and public health responsibilities proposed by the Task Force. Current statutory language accurately reflects some activities of state and local public health programs while retaining outdated and archaic language which is essentially ignored. For example, the Department is directed to advise state agencies on location, drainage, water supply, disposal of excreta, heating, plumbing, sewer systems, and ventilation of public buildings, yet there is no systematic method set up where the Department is advised of these types of activities sponsored or authorized by other state agencies.

While there is typically a local or state Department of Commerce regulatory check on these activities, there is no consistent assurance that the Department of Public Health and Human Services will advise the agencies involved regarding public health concerns.

Statutory requirements of local boards of health are also not consistently followed. By law, local boards shall meet at least quarterly, appoint a local health officer, supervise destruction of and removal of all filth that cause disease, guard against the introduction of communicable disease, supervise inspections of public establishments for sanitary conditions, and adopt regulations for control and disposal of sewage from private and public buildings.

There are also several provisions which are optional activities for local boards. Information obtained through the local health department resource assessment referred to in section 3 of this report indicates that there is great variation among the local boards regarding frequency of meetings. Additionally, several local boards of health rarely met to discuss issues related to public health nursing, communicable disease, or other issues unrelated to regulation of food service and other consumer establishments.

4.2 Conclusions of the Statutory Review



he presence of outdated language in Montana's statutes relative to public health does not appear to always result in significant operational problems. However, it is apparent that the various public health Responsibilities in the Montana Codes Annotated could be made more effective if the following recommendations are implemented:

- eliminate language that is no longer valid or relevant
- adopt language as necessary to reflect current public health activities
- clearly establish governmental responsibilities to the public regarding public health
- clearly establish the roles and responsibilities of state public health agencies, local public health agencies, local public health officers, a state public health officer, and local boards of health
- clearly establish relationships between local health agencies and county commissions

- institute a method for adoption of public health standards, for which there should be appropriate funding levels.

5. RECOMMENDATIONS

The Task Force spent considerable time addressing future public health improvement activities. Indeed, the term "improvement" implies an ongoing commitment to action. As a result, these discussions led to the following set of recommendations for continuous public health improvement in Montana. While the Task Force dissolves with the sunset of the Public Health Improvement Act on September 30, 1996, the members agreed that the strategy involved with adoption of these recommendations will provide for that continuity.

RECOMMENDATION NUMBER ONE

THE PUBLIC HEALTH IMPROVEMENT TASK FORCE RECOMMENDS THAT FUNDING WITH AUTHORITY FOR LOCAL AND PRIVATE MATCH BE SECURED FROM THE LEGISLATURE TO PROVIDE GRANTS TO LOCAL PUBLIC HEALTH AGENCIES TO ASSIST THEIR EFFORTS TO MEET PUBLIC HEALTH RESPONSIBILITIES.

During the process to promote a universal and realistic set of public health Responsibilities for the recommended Core Functions, the most often asked question was, "Who will pay for them?" Looking at state and local public health Responsibilities, a short answer might easily be that "we" already are. Public health departments spend their limited resources for categorical public health programs or to respond to immediate needs. As a result, some of the most critical responsibilities of public health agencies, primarily those associated with public health Responsibilities, are not done.

"We" as a population, "pay" for that inability to meet public health Responsibilities through costly medical care and other social costs down the road. When there is not a universal set of Responsibilities to provide consistent guidance, state and local public health programs are unable to fully meet public health needs defined statewide and at the local level. But the issue is clear, if the proposed public health Responsibilities are realistic and adequate, any recommendation for their

adoption is pointless unless there are corresponding recommendations for appropriate funding.

Therefore, the Task Force recommends that the 1997 Legislature approve budget authority for $450,000 over the 1999 biennium to allow the Department to provide grants to local public health agencies. The funds would consist of $200,000 general fund appropriation, with authority to match $100,000 local public health agencies' resources and $150,000 private grant sources. The Task Force will provide guidance to the Department in developing criteria to fund core public health services based on each county's ability to demonstrate where Core Functions are not now adequately funded. The criteria for these grants will be developed prior to June 30, 1997. The grant applications will be expected to address how local public health agencies are not meeting core functions and, with the grants, can implement strategies to meet them. Counties will be encouraged to submit joint applications, especially in rural areas where public health services are already shared. The grant process will be implemented with an expectation that the Department will provide necessary technical assistance to local agencies.

RECOMMENDATION NUMBER TWO

THE PUBLIC HEALTH IMPROVEMENT TASK FORCE RECOMMENDS THAT AN IMPORTANT FIRST STEP TO IMPLEMENTING THE PROPOSED CORE FUNCTIONS AND PUBLIC HEALTH RESPONSIBILITIES IS TO COMPLETE A COMPREHENSIVE ANALYSIS OF THE CAPACITY OF MONTANA'S LOCAL PUBLIC HEALTH AGENCIES TO PERFORM THESE FUNCTIONS AND RESPONSIBILITIES.

To implement a plan for improving public health services in Montana, it is critically important to understand the capacity of local public health agencies to perform the proposed Core Functions and Responsibilities. The Task Force determined that an in-depth study of capacity based on an analysis of each agency's ability to perform the Functions and Responsibilities outlined in Section 3 is a critical component of Montana's Public Health Improvement Plan. That analysis should occur as an important first step in the implementation of the plan.

Although a comprehensive analysis could not be performed, preliminary findings from the following two studies on public health resources and capacity were used by the Task Force to assist in determining proposed public health Responsibilities.

- A survey of the perceived adequacy of county public health agencies to perform public health core functions completed in 1994 by the Montana Committee for Improving Public Health, titled *Adequacy of Public Health Core Functions in Montana Counties*.

- A survey of public health agency resources completed for the Task Force, by David Green, Michelle Hastings, Watcharapong Kritprad, and Brent Morrow as partial fulfillment of the requirements of a Masters of Public Administration at the University of Montana, titled *County Public Health Departments in Montana: A Preliminary Inventory of Existing Resources*.

RECOMMENDATION NUMBER THREE

THE PUBLIC HEALTH IMPROVEMENT TASK FORCE RECOMMENDS THAT THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES FACILITATE CONTINUED PUBLIC HEALTH IMPROVEMENT ACTIVITIES WITH THE CONTINUANCE OF THE TASK FORCE WHICH WILL BE ATTACHED TO THE HEALTH POLICY AND SERVICES DIVISION.

The Task Force has agreed to not seek renewal of the Public Health Improvement Act during the 1997 Legislature. Rather, with the concurrence of the Department, the Task Force will continue public health improvement oversight as a part of the Health Policy and Services Division. As the Department seeks to gain greater efficiencies through the consolidation of various advisory and work groups, it intends to secure operational funds for a continued public health improvement effort out of current level resources. Therefore, no legislation is required for this recommendation.

RECOMMENDATION NUMBER FOUR

THE PUBLIC HEALTH IMPROVEMENT TASK FORCE RECOMMENDS A WORK GROUP BE CONVENED TO STUDY AND MAKE RECOMMENDATIONS REGARDING LOCAL PUBLIC HEALTH AGENCY BUDGET REPORTING.

During the process, the Task Force also became aware of problems resulting from local public health budget reporting, making accurate financial calculations of public health services difficult to achieve. Public health activities are not widely understood and therefore not always reported in correct line items or with other public health activities or programs. For example, many counties do not report environmental health functions conducted by sanitarians in their public health agency budgets. Some counties group environmental health programs with public safety activities, and others in general government operations.

The Montana Association of Counties has recommended that public health budget reporting occur with greater consistency through use of one budget format which details all public health activities. The Task Force wholeheartedly agrees. It is this work group -- consisting of the Departments of Public Health and Human Services, Commerce, and Environmental Quality, the Montana Association of Counties, the League of Cities and Towns, local public health agencies, boards of health and health officers, county clerks and recorders, accountants experienced in county audits, the Office of Budget and Program Planning, and the Legislative Fiscal Analyst -- that should develop a consistent format for reporting purposes, and propose a training methodology to assist the Department of Commerce in its training activities for local clerks and recorders. Ultimately, consistent and reliable budget reporting will allow for accurate determinations of the costs of public health programs and services, a detailed understanding of revenue sources, and assist the Department of Public Health and Human Services in its attempts to maximize potential revenue from federal public health and Medicaid programs for local public health programs.

RECOMMENDATION NUMBER FIVE

THE PUBLIC HEALTH IMPROVEMENT TASK FORCE RECOMMENDS THAT THE DEFINITION OF PUBLIC HEALTH AND SIX CORE FUNCTIONS PROPOSED BY THE TASK FORCE BE INCORPORATED INTO MONTANA'S PUBLIC HEALTH LAWS.

The Task Force recognizes that there are features of the 1995 Public Health Improvement Act that should be kept in law. The 1995 Act included a set of Core Functions based on those of the State of Washington. However, the Task Force developed a definition of public health and corresponding core functions which are specific to the State of Montana. By incorporating the definition and core functions into law, the Task Force intends to make them applicable only to the public health laws located in Title 50, Chapters 1 and 2. As a result, there should be no conflict with the other numerous statutory references to public health. It is also recommended that the core functions are referred to in the statutes as goals which local and state public health agencies should be trying to achieve. This recommendation will require legislation.

RECOMMENDATION NUMBER SIX

THE PUBLIC HEALTH IMPROVEMENT TASK FORCE RECOMMENDS THAT PUBLIC HEALTH AGENCIES PARTICIPATE IN CHANGING HEALTH SERVICE SYSTEMS AT THE COMMUNITY LEVEL, SUCH AS MANAGED CARE, AND DESCRIBE THOSE SERVICES AND THEIR IMPACTS IN COMMUNITIES.

Montana policy-makers have been struggling with efforts directed to improving access and finding more efficient ways to deliver health care services. The concepts include a host of terms, such as health care reform, cost containment, individual responsibility, managed care, medical assistance facilities, and rural health clinics, which are finding footholds in a health care vocabulary. These health service initiatives and systems affect the way public health services are delivered. The Task Force understands that public health activities cannot be planned and conducted in isolation

from the rest of the health care system, especially when there is a reliance in some communities for delivery of public health services to be an effort coordinated with health care facilities or services other than public health. The Task Force strongly encourages partnerships to continually evolve at the community level to ensure healthy communities.

For those types of partnerships to work, there must be a clear understanding of the roles and responsibilities of public health. The Task Force has the ability to provide opportunity to refine public health Responsibilities where partnerships can respond to changing public health needs identified through cooperative arrangements. For example, public health has specific Responsibilities to identify the health problems and risks in communities and to provide certain population based services, but direct services can be delivered in as many ways as there are communities.

An important part of being able to constructively participate in these community decisions is adequate funding for public health Responsibilities. As an example, a public health agency that funds a Maternal and Child Health Clinic, but has no funding for ***assessment*** of maternal and child health issues in the community, will find limitations in its ability to target health problems and implement preventive strategies associated to children's health in the community. The agency must continue its work through the clinic in order to be able to carry out it's basic Responsibilities. However, if the proposed public health Responsibilities are adequately funded, then the public health agency can actively participate in community negotiations that determine the most efficient and effective provision of clinic services while also being able to conduct critical assessment activities.

RECOMMENDATION NUMBER SEVEN

THE PUBLIC HEALTH IMPROVEMENT TASK FORCE RECOMMENDS CHANGES TO LICENSURE AND THE FEE STRUCTURE OF FOOD ESTABLISHMENTS, INCLUDING MOVING FEES OUT OF MONTANA LAWS AND PLACING THEM IN ADMINISTRATIVE RULE.

The Task Force discussed several issues associated with food establishment safety during the past year. As both assessment and protection activities, food establishment inspections are directly related to Core Functions. Currently, most local public health agencies conduct inspections and enforcement of state regulations. Some counties have a modified inspection agreement with the state in order to reduce the mandated semi-annual inspections for some facilities. As defined by statute, food establishments are required to pay a $60 annual licensure fee to the state, which is

shared between the state and counties. The local share of the licensure fees (85 percent) is earmarked to pay for the inspection and enforcement process. A change in statute is necessary to carry out this recommendation.

For a number of years, the Food and Consumer Safety Section (F&CSS) has been tracking actual costs of inspections. Records indicate that the current statutory fee structure does not adequately cover the costs for the inspections and enforcement activities. This fact was clearly pointed out in a recent Legislative Audit report. The Food and Consumer Safety Section and representatives from local public health agencies have proposed instituting a new fee system which accomplishes several objectives.

First, the participants in this effort recommend removal of a fee structure from the statutes and instead adopt a new fee system by administrative rule. A fee schedule would be developed with representatives of the food industry. Second, F&CSS would like to stagger issuance of annual licenses, and remove the statutory requirement that all licenses expire on December 31 of each year. Third, F&CSS proposes those license fees be based on costs which would include level of risk for different types of food establishments. Currently, all food establishments are assessed licensure fees irrespective of their size or complexity. Consequently, a small espresso stand on a street corner pays the same rate as a major grocery store with a meat market, bakery, and deli attached.

RECOMMENDATION NUMBER EIGHT

THE PUBLIC HEALTH IMPROVEMENT TASK FORCE SUPPORTS THE EFFORTS OF THE HEALTHY COMMUNITIES COALITION WHICH WILL RESULT IN COMMUNITY-INITIATED PUBLIC HEALTH IMPROVEMENT ACTIVITIES ACROSS THE STATE.

The Task Force believes that a current effort, the Montana Healthy Communities Coalition, provides an exceptional opportunity for public health improvement activities to be initiated at the local level by community leaders. The Coalition is requesting funds in FY 1998 and FY 1999 to support the development of these initiatives across the state. The initiatives are citizen-led processes through which communities collaborate across traditional boundaries to explore their unique assets, identify needs, prioritize broad-based health issues, and develop action plans to address problems of immediate or greatest concern. The funds will finance training and technical assistance, and be used as “mini-grants” to support local initiatives. The Coalition will be coordinated through the Department’s State Prevention Resource Center. The

budget request is for $30,000 general fund and $30,000 matching cash or in-kind from local projects for each year of the biennium.

The Task Force also suggests a collaboration between Coalition activities and the Department in its effort to conduct comprehensive needs assessments as required by the federal Maternal and Child Health Block Grant. This type of collaboration is vital to securing the appropriate allocation of federal funds to counties.

RECOMMENDATION NUMBER NINE

THE PUBLIC HEALTH IMPROVEMENT TASK FORCE RECOMMENDS THAT REQUIRED REPORTING BY LOCAL PUBLIC HEALTH AGENCIES, PRIMARILY FOR STATE AND FEDERAL GRANTS, BE STREAMLINED WHERE POSSIBLE THROUGH CHANGES IN ADMINISTRATIVE PROCEDURES.

Currently, local public health agencies have a variety of state and federal funding. Typically, each funding source requires separate accounting or cost reporting procedures. Local public health agencies could potentially dedicate more resources to direct services if fewer reports could accommodate existing funding requirements.

Additionally, federal reimbursement practices were identified by rural counties as problematic in that local public health services typically obligate other county funds and resources before reimbursement occurs when they are already under extreme budgetary constraints. The Task Force recognizes this as an issue where the federal, state, and local governments must communicate better with each other, identify problems, and work to see that needed public health services are not disrupted.

RECOMMENDATION NUMBER TEN

THE PUBLIC HEALTH IMPROVEMENT TASK FORCE RECOMMENDS A FUTURE EFFORT BE DEDICATED TO EXAMINING STRATEGIES TO MAKE SUCCESSFUL PILOT PROJECTS PERMANENT.

Pilot projects or demonstration grants, typically provide for new proposals on a one-time or short-term basis. The Task Force recognizes that too often good ideas are shelved because grant funding runs out, or the temporary nature of pilot projects create

disincentives to seek funds in the first place. Therefore, there is a need for public health agencies to have a meaningful system available which makes it easier to transition successful temporary initiatives into successful permanent programs. Such a system also promotes the strengthening of partnerships among participants in public health.

RECOMMENDATION NUMBER ELEVEN

THE PUBLIC HEALTH IMPROVEMENT TASK FORCE RECOMMENDS THAT THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES COLLABORATE WITH THE DEPARTMENT OF ENVIRONMENTAL QUALITY, LOCAL PUBLIC HEALTH AGENCIES, APPROPRIATE FEDERAL AGENCIES, AND THE MONTANA UNIVERSITY SYSTEM TO DEVELOP A PUBLIC HEALTH TRAINING INSTITUTE.

The proposed public health Responsibilities contain several references to implementation or consistent application of training programs for local and state public health department personnel. This is viewed as a critical activity where the Task Force can have an oversight function in developing training programs. The Task Force also recommends that the Department engage the services of an entity capable of coordinating and facilitating various training programs for state and local agency staff. Coordination and facilitation funding would be internal and sought externally from private foundations and the federal government.

RECOMMENDATION NUMBER TWELVE

THE PUBLIC HEALTH IMPROVEMENT TASK FORCE RECOMMENDS THAT THE STATE AND LOCAL PUBLIC HEALTH AGENCIES TAKE LEADERSHIP ROLES IN PROVIDING INFORMATION TO THE PUBLIC ABOUT PUBLIC HEALTH.

The Task Force found that Core Functions and public health Responsibilities will be acceptable to local health agencies as long as there is a general understanding of the concepts involved. This also requires the opportunity for individuals in communities to understand how public health agencies and programs impact their daily lives. Extremely important is the need to inform the public of the effectiveness of successful

public health in assisting the Department and other relevant agencies in designing effective educational programs.

RECOMMENDATION NUMBER THIRTEEN

THE PUBLIC HEALTH IMPROVEMENT TASK FORCE RECOMMENDS THAT A THOROUGH REVIEW OF STATE PUBLIC HEALTH LAWS BE COMPLETED WITH THE ASSISTANCE OF LEGAL COUNCIL AND THE APPROPRIATE STATE AND LOCAL PUBLIC HEALTH AGENCIES.

Included in this plan is a preliminary review of Montana statutes which affect public health in various ways. Further review is necessary to: a) propose elimination of language that is no longer relevant; b) propose adoption of language necessary to reflect current public health activities; c) clearly establish governmental responsibilities to the public regarding public health; d) clearly establish roles and responsibilities of state and local public health agencies, health officers, and boards of health; and e) clearly establish relationships between local health agencies and county commissions.